MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Positive Pain Management 2301 Forest Lane, Ste. 310 Garland, TX 75042	MDR Tracking No.: M4-03-8440-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Commerce & Industry Insurance Co. c/o Flahive Ogden & Latson P.O. Box 13367 Austin TX 78711 BOX 19	Date of Injury: Employer's Name: Southeast Keller Corp. Insurance Carrier's No.: 077080683

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
02/11/03	**02/14/03**	**97799-CP-AP**	**$4,025.00**	**$4,025.00**

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 07/07/03 states in part, "…Mr. ___ participated in the Pain Management Program… HDI preauthorized these services, preauthorization # 011943901, 011943902, and 011943903. Per EOB, 'the charge(s) have been denied due to payor's utilization review company'.. This was not a sufficient reason for the denial because preauthorization was obtained for the service. The unpaid claims were the 28th, 29th, and 30th days of the Pain Management Program. All the other claims were already paid…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary dated 07/29/03 states in part, "…This case involves DOS 22/11/03-2/14/03 (CPT Codes 97799-CP-AP & 99082)… Carrier notes that ALL preauthorization certifications had expired by the time the HCP accomplished the services. This means that medical necessity and preauthorization requirements whould have had to have been met for reimbursement and they were not…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

On February 3, 2005 the requestor submitted a withdrawal of CPT Code 99082. Therefore, this code is no longer in dispute and will not be reviewed.

- CPT Code 97799-CP-AP (23 hours) for dates of service 02/11/03 through 02/14/03 denied as "FU – Accredited interdisciplinary program and The charge(s) have been denied due to the payor's utilization review company". Per Rule 133.301(a) the services rendered were preauthorized. The preauthorization approval, Certification #: 011943903, certified 80 hours; therefore reimbursement of $4,025.00 ($175.00 x 23 hours) is recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
2/11/2003	97799-CP-AP	$1,225.00	$1,225.00				
2/13/2003	97799-CP-AP	$1,400.00	$1,400.00				
2/14/2003	97799-CP-AP	$1,400.00	$1,400.00				
				Total Left Column:			$4,025.00
				Total Amount Due:			$4,025.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $4,025.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Typed Name	02-04-05 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____